Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
SUMMIT REHABILITATION CENTERS

Respondent Name
ST PAUL FIRE & MARINE INSURANCE COMPANY

MFDR Tracking Number
M4-05-A256-01

Carrier's Austin Representative Box
Box Number 5

MFDR Date Received
July 8, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "All fee guidelines have been followed for these services, they are not global."

Amount in Dispute: $384.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The denials were based on a Required Medical Examination performed on 2-3-05 . . ."

Response Submitted by: St. Paul Fire and Marine Insurance Company, PO Box 143131, Irving, Texas 75062

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 14, 2004 to October 12, 2004	Outpatient Rehabilitation Services	$2,631.04	$1,569.52

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202 sets out the fee guidelines for professional medical services.
3. 28 Texas Administrative Code §180.22 establishes heath care provider roles and responsibilities.
4. Texas Labor Code §408.021 sets out provisions regarding entitlement to medical benefits.
5. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
6. The requestor submitted an amended Table of Disputed Services dated September 3, 2008. The Division will consider the remaining disputed services as indicated in the requestor's amended table as the basis for this review. The amount in dispute is the amount as listed on the requestor's revised table.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - F – FEE GUIDELINE MAR REDUCTION
   - 97 – Payment is included in the allowance for another service/procedure.
   - 663 – REIMBURSEMENT HAS BEEN CALCULATED ACCORDING TO THE STATE FEE SCHEDULE GUIDELINES.

- G – UNBUNDLING
- W1 – Workers Compensation State Fee Schedule Adjustment
- 210 – THE VISIT HAS BEEN INCLUDED IN THE TREATMENT PERFORMED.
- K – NOT APPROPRIATE HEALTH CARE PROVIDER
- 993-002 – SERVICE DENIED. PROVIDER NOT ON THE APPROVED DOCTOR LIST.
- 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
- 891-100 – PER CARRIER/ADJUSTER PAYMENT HAS BEEN CANCELLED $0.00
- 313 – THE PROCEDURE CODE BILLED IS NOT APPROPRIATE FOR USE BY THE PROVIDER.
- 902-101 – MEDICAL RECORDS ATTACHED
- L – NOT TREATING DOCTOR APPROVED TREATMENT
- 882 – THE SERVICES WERE NOT PERFORMED BY THE TREATING PHYSICIAN $0.00
- 17 – Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.
- 902-101 – MEDICAL RECORDS ATTACHED
- 38 – Services not provided or authorized by designated (network/primary care) providers.

Findings

1. Division rule at 28 Texas Administrative Code §133.307(d), effective January 1, 2003, 27 *Texas Register* 12282, requires that "A person or entity who fails to timely file a request waives the right to medical dispute resolution. The commission shall deem a request to be filed on the date the division receives the request, and timeliness shall be determined as follows: (1) A request for medical dispute resolution on a carrier denial or reduction of a medical bill pursuant to §133.304 of this title (relating to Medical Payments and Denials) or an employee reimbursement request shall be considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute." The request for dispute resolution of services rendered from dates of service June 14, 2004 to July 7, 2004 was received by the Division on July 8, 2005, which is later than one year after the dates of service. The Division finds that the request for dispute resolution was not submitted timely. The Division concludes that the requestor has not met the requirements of §133.307(d). Therefore service dates June 14, 2004 through July 7, 2004 will not be considered in this review. However, the request for dispute resolution of services rendered from July 8, 2004 through October 12, 2004 was submitted in accordance with the timely filing requirements of §133.307(d); therefore, these services will be considered in this review.
2. The respondent's position statement asserts that "The denials were based on a Required Medical Examination performed on 2-3-05. . . " Per 28 Texas Administrative Code §133.307(j)(2), effective January 1, 2003, 27 *Texas Register* 12282, "The response shall address only those denial reasons presented to the requestor prior to the date the request for medical dispute resolution was filed with the division and the other party. Responses shall not address new or additional denial reasons or defenses after the filing of a request. Any new denial reasons or defenses raised shall not be considered in the review." No documentation was found to support that the respondent presented these denial reasons to the requestor prior to the date that the request for medical dispute resolution was filed with the Division, therefore these newly raised denial reasons or defenses shall not be considered in this review.
3. The insurance carrier denied disputed services rendered October 12, 2004 with payment exception code L – "NOT TREATING DOCTOR APPROVED TREATMENT"; with additional denial reason explanation codes 882 – "THE SERVICES WERE NOT PERFORMED BY THE TREATING PHYSICIAN $0.00"; and 38 – "Services not provided or authorized by designated (network/primary care) providers." Per former version of Division rule at 28 Texas Administrative Code §180.22(c), effective March 14, 2002, 27 *Texas Register* 1817, "The treating doctor shall: (1) except in the case of an emergency, approve or recommend all health care rendered to the employee including, but not limited to, medically reasonable and necessary treatment or evaluation provided through referrals to consulting and referral doctors or other health care providers" Additionally, Texas labor Code §408.021(c) requires that "Except in an emergency, all health care must be approved or recommended by the employee's treating doctor." Review of Division records finds that the injured employee had a change in treating doctor effective October 5, 2004. Review of the submitted information finds that the rendering physician was not the approved treating doctor on the date of service. No information was found to support that the disputed services were approved or recommended by the injured employee's treating doctor. No documentation was found to support an emergency. The insurance carrier's denial reasons are supported. Reimbursement cannot be recommended for date of service October 12, 2004.
4. The insurance carrier denied disputed services with payment exception code K – "NOT APPROPRIATE HEALTH CARE PROVIDER"; with additional explanation code 993-002 – "SERVICE DENIED. PROVIDER NOT ON THE APPROVED DOCTOR LIST." Review of box 31 of the medical bill finds that the rendering physician was Dr, Marivel Subia. Review of Division records finds that Dr. Marivel Subia was a Division approved doctor on the Approved Doctor List on the disputed dates of service. These denial reasons are not supported. These disputed services will therefore be reviewed for payment according to applicable Division rules and fee guidelines.

5. The insurance carrier denied disputed services billed under procedure code 99213 with payment exception code G – "UNBUNDLING"; with additional denial reason explanation codes 97 – "Payment is included in the allowance for another service/procedure"; and 210 – "THE VISIT HAS BEEN INCLUDED IN THE TREATMENT PERFORMED." Per 28 Texas Administrative Code §134.202(b) "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." Further, per §134.202(a)(3), "Notwithstanding Centers for Medicare and Medicaid Services (CMS) payment policies, chiropractors may be reimbursed for services provided within the scope of their practice act." Review of the Medicare program coding, billing and reporting payment policies finds no information to support that this service is bundled or included in the payment allowance for any other services performed on the same dates. No documentation was found to support the insurance carrier's denial reasons. The disputed services will therefore be reviewed for payment according to applicable Division rules and fee guidelines.
6. This dispute relates to professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.202(c)(1), effective January 5, 2003, 27 *Texas Register* 4048 and 12304, to determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: "for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%." The services in dispute were billed under evaluation and management code 99213. The Medicare payment amount for the disputed service is $54.59. This amount multiplied by 125% is $68.24. Payment is recommended for disputed dates of service July 8, 9, 12, 13, 14, 16, 19, 20, 22, 23, 26, 28, 29, 30; August 2, 3, 6, 9; September 17, 21, 30; October 5, and 7, 2004, for a total of 23 visits. $68.24 multiplied by 23 visits results in a total reimbursement of $1,569.52. This amount is recommended.
7. The total recommended reimbursement is $1,569.52. The insurance carrier has paid $0.00, leaving an amount due to the requestor of $1,569.52. This amount is recommended.

Conclusion

For the above reasons, the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,569.52.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,569.52 plus applicable accrued interest per 28 Texas Administrative Code §134.803, and/or §134.130 if applicable, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	April 11, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.